STRONG MINISTRIES for STRONG HEALTH SYSTEMS

An overview of the study report:

Supporting Ministerial Health Leadership: A Strategy for Health Systems Strengthening

by

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Abbreviations	
ACHEST	African Center for Global Health and Social Transformation
ASHGovNET	African Health Systems Governance Network
AU	African Union
CDC	Centers for Disease Control and Prevention (US)
FMOH	Former Minister of Health
GAVI	Global Alliance on Vaccines Immunization
GFATM	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
H8	Health 8: WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, Gates, World Bank
HRPI	Health Resource Partner Institution
LIC	Low-income country
MDG	Millennium Development Goals
MIC	Middle-income country
MOF	Ministry of Finance
MOH	Minister (Ministry) of Health
NGO	Non-governmental organization
NYAM	New York Academy of Medicine
PAHO	Pan American Health Organization
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPAN	United Nations Public Administration Network
UNSG	United Nations Secretary General
VGRC	Virtual Global Resource Center
WB	World Bank
WBI	World Bank Institute
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

Foreword

Strengthening health systems is a major priority of The Rockefeller Foundation. Through this effort the Foundation is supporting better health and financial protection for poor and vulnerable people through improved health systems performance and progressive adoption of universal health coverage.

Beyond evidence-based agenda setting at a global level, the Foundation sees three pillars of this effort at country level: building capacity for effective health systems stewardship; harnessing the role of the private sector in mixed systems; and promoting interoperable eHealth systems. This report was commissioned to address the key area of ministerial stewardship, and to explore models for supporting ministers and ministries of health, especially those in low-income countries, so that they may effectively discharge their responsibilities for stewardship and governance of country-level health systems, and their international linkages and partnerships.

While the stewardship function appears in every conceptual model of health systems, very little has been done to strengthen the ministries of health, which are the central institutions responsible for stewardship of health systems at the country level. This report is an effort to address the gaps in our understanding of the roles ministries play, their needs, and the challenges they face, so that we can take effective action to strengthen them. Francis Omaswa and Jo Boufford allow us to hear the core issues in the ministers' own voices, as well as the views of global health leaders who depend on ministries for the success of their initiatives at country level.

Implementing the recommendations offered by ACHEST and NYAM is an important step toward strengthening ministries of health to be truly powerful leaders, facilitating their ability to provide the opportunities for people to be as healthy as they can be.

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About the Overview

This overview is adapted from the report *Supporting Ministerial Health Leadership: A Strategy for Health Systems Strengthening* by Dr. Francis Omaswa, executive director and founder of The African Center for Global Health and Social Transformation (ACHEST) and Dr. Jo Ivey Boufford, president of The New York Academy of Medicine (NYAM).

The study and report were commissioned by the Rockefeller Foundation to explore the feasibility of establishing a support mechanism for ministers and ministries of health especially in the poorest countries, as part of the Foundation's Transforming Health Systems initiative,

The study was initially designed to assess the potential value of three proposed programs to strengthen the leadership capabilities of ministers of health:

- a global executive leadership program for new ministers;
- an ongoing, regional, in-person and virtual leadership support program for sitting ministers; and
- a virtual global resource center for ministers and high level ministerial officials providing real-time access to information.

During the course of the study, it became clear that it was essential to expand the inquiry to better understand the challenges and needs of ministries as a whole, as they and their ministers provide the stewardship function for country health systems.

The content of the report was derived from six major activities:

- a comprehensive literature review of the theory and practice of effective leadership development and organizational capacity building, and an environmental scan to identify any existing or planned leadership development programs for ministers of health or any that have occurred in the recent past globally;
- a survey of the turnover of ministers of health;
- targeted interviews with ministers, former ministers, and key stakeholders who interact with them, conducted between October 2008 and September 2009, to better understand the roles of ministers and ministries, the challenges they face, resources at their disposal, and their thoughts on what additional resources might enhance their personal effectiveness and that of their ministries;
- a consultative meeting of experts and stakeholders held in Bellagio, Italy part way through the project;
- participation of the project leaders (Omaswa and Boufford) in relevant global and regional meetings, as well as individual meetings about the project with critical leaders in international and donor organizations and potential champions of this effort; and
- a consultation with African regional health leaders to discuss the final report, held in Kampala, Uganda.

To assure candid responses and confidentiality, minister and stakeholder comments presented throughout this overview are paraphrased and not attributed by name.

Many of the resources referred to throughout this overview are available on the internet, and a list of website addresses is provided in appendix 1.

The key findings and recommendations from the full report are provided in this overview. The full report, including six associated data appendixes, is available online at www.strongministries.org, or by contacting NYAM in the US (phone: (212) 822-7201, web: www.nyam.org) or ACHEST in Uganda (phone: +256 414 237225, email: info@achest.org).

Report Highlights

- Strengthening health systems has emerged as a priority in global and national health policy and practice.
- A **health system** is defined for the purposes of this report as consisting of four core elements: personal health care services, public or population health services, health research systems, and health in all policies. Effective health systems strengthening requires attention to all four of these elements.
- Governments are **stewards,** or protectors, of the public interest and have the ultimate responsibility for assuring conditions that allow people to be as healthy as they can be. Ministries of health and the ministers who lead them must be able to perform a set of core stewardship functions within the ministry and across government. Stewardship is one of the central building blocks of an effective health system.
- Health ministries must also work effectively with an increasing number of non-governmental partners who bring important knowledge, expertise, and advocacy to help them meet their responsibilities (e.g. universities, professional associations, academies of medicine and science, business, civil society). **Governance** is the alignment of multiple actors and interests, such as these, to promote collective action towards an agreed upon goal, in this case, to assure the best use of resources for health.
- Despite the central role ministers and ministries of health play in these processes, they are currently overlooked when investments are being made and initiatives are being designed to strengthen health systems.
- Among the ministers and stakeholders interviewed, there was significant support for the specific proposals for an executive leadership development program for new ministers, leadership support for sitting ministers, and the establishment of a virtual information resource center on health systems stewardship and governance.
- There is a need to build awareness among politicians, policy makers, and the public, of the importance of stewardship and governance in strengthening health systems, and the critical role of ministers and ministries of health.
- Based on data from minister and stakeholder interviews and supporting research and consultation activities, this report offers seven action items geared toward building **a systematic and sustained program of support for health ministries.** Recommendations and proposals provided address:
  - Capacity assessment tools
  - Leveraging existing management development resources
  - Mapping country networks of expertise
  - Regional networks to support health systems stewardship and governance
  - A knowledge network for ministers of health
  - Executive leadership development
  - Advocacy for strengthening health ministries
- Collective action on these proposals is needed to strengthen health ministries, enhance the leadership capabilities of ministers, and assure their full ability to serve as effective stewards of health resources in the drive to achieve national, regional, and global health objectives.

Introduction

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..." states the constitution of the World Health Organization (WHO).[1] Beyond the individual right to health, the health of the population is recognized as an invaluable asset that is closely associated with social and economic development. Accordingly, progress in health is at the core of most of the United Nations (UN) Millennium Development Goals. And yet, disparities in health persist worldwide. Morbidity and mortality due to preventable causes remain unacceptably high. Nowhere is this more apparent than in low-income countries in the developing world.

The health of the people is directly related to effective health systems. Strengthening of health systems has emerged as a priority in global and national health policy and practice because a gap remains between *knowing* what can make a difference in the health of individuals and populations, and *taking action* to achieve results. In order to close this implementation gap and achieve the prevention and treatment goals of traditional disease-specific programs, a comprehensive national health system that works for the entire population is needed.

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..." –WHO

Although numerous high profile reports[2] have stressed the central role of *stewardship* and *governance* in health systems strengthening, very little systematic attention has been paid to enhancing these functions. Government has a primary role in assuring effective health systems and services, whether as a direct provider, or through relationships with private providers. The *ministry of health* is the government agency generally responsible for the health of the people through the adoption and implementation of health policies and programs, achieved though stewardship and governance of health resources. A minister's individual effectiveness however, is impacted by the level of institutional support the ministry receives. As ministers strive to fulfill their mandate, the role and capacity of ministries of health are too often overlooked when investments to strengthen health systems are made.

A gap remains between knowing what can make a difference in the health of individuals and populations, and taking action to achieve results.

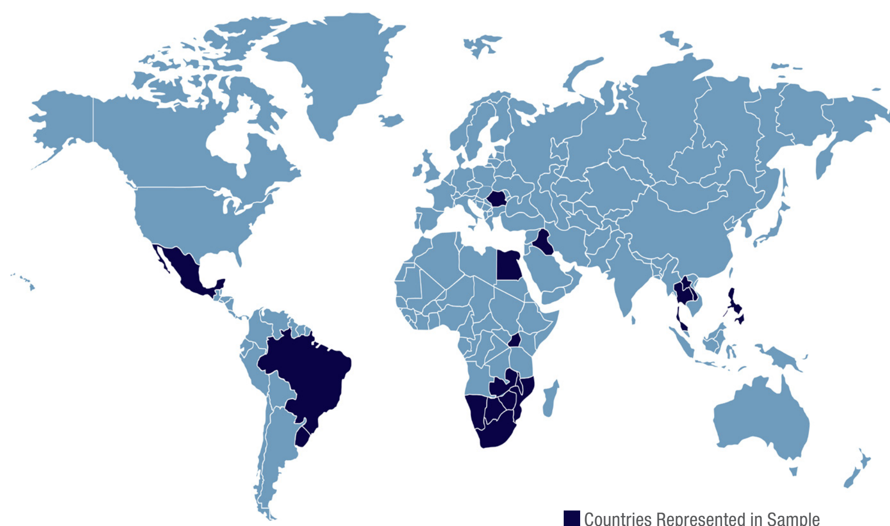
A minister's individual effectiveness is impacted by the level of institutional support the ministry receives.

Through detailed interviews with those who know these issues best — the ministers and their stakeholders — this report examines the roles of health ministries, their resource needs, and the challenges they face. Based on the candid and thoughtful input of those interviewed, and the supporting research and consultation activities, this report offers seven action items geared toward building a systematic and sustained program of support for health ministries. Implementation of these proposals can help strengthen health ministries, enhance the leadership capabilities of ministers, and restore their full ability to serve as effective stewards of health resources in the drive to achieve national, regional, and global health objectives.

1. Constitution of the World Health Organization, 45th edition (2006). Online at http://www.who.int/governance/en/
2. World Health Report 2000 - Health Systems: Improving Performance (The World Health Organization, WHO, 2000); World Development Report 2004: Making Services Work for Poor People (The World Bank, 2004); Opportunities for Global Initiatives in the Health System Action Agenda (WHO Working Paper No. 4, 2006); Towards Better Leadership and Management in Health (WHO Working Paper No. 10, 2007); Health Financing Revisited (The World Bank, 2006); Public Stewardship of Private Providers in Mixed Health Systems (Commissioned by the Rockefeller Foundation, 2009); Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health (WHO Commission on Social Determinants of Health, 2008). Website addresses for reports available online are provided in Appendix 1.

Data Collection Methods

The primary method of data collection for this study was targeted interviews with ministers, former ministers, and key individuals who interact with them. This was deemed to be the best way to understand the roles of ministers and ministries, the challenges they face, resources at their disposal, and their thoughts on what additional resources might enhance their personal effectiveness and that of their ministries. Interviews were conducted between October 2008 and September 2009 with 11 current and 13 former ministers of health (24 total, see Map) and with 20 high-level stakeholders (including senior civil servants, parliamentarians, academics, donors, leaders of international organizations and global organizations of civil society). Represented stakeholder organizations included (but were not limited to) WHO and its regional offices; the Gates Foundation; The Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Economic Forum; Harvard University; Global Alliance for Vaccines and Immunization (GAVI); the UN Department of Economic and Social Affairs (UNDESA); the World Bank and World Bank Institute; ; the International Health Partnership; and the African Union Commission. Interviews were conducted in person or by phone by Drs. Boufford and Omaswa, and by Sheila Dinotshe Tlou, Member of Parliament, Botswana. As international leaders in public health and peers of the interviewees, the interviewers were able to facilitate open and nuanced discussions, enhancing the data collection. Interviews followed semi-structured guides specific to either the minister or stakeholder role. To foster uninhibited discussion of potentially sensitive topics, interviewers took detailed notes rather than audio taping the interviews. As such, respondent comments included in this overview and in the full report may be paraphrased rather than quoted directly. All study participants were assured of confidentiality and comments are not attributed by name. Notes were transcribed and themes were coded using NVIVO, a widely utilized qualitative research software package.



Other activities that informed the content of this report included:

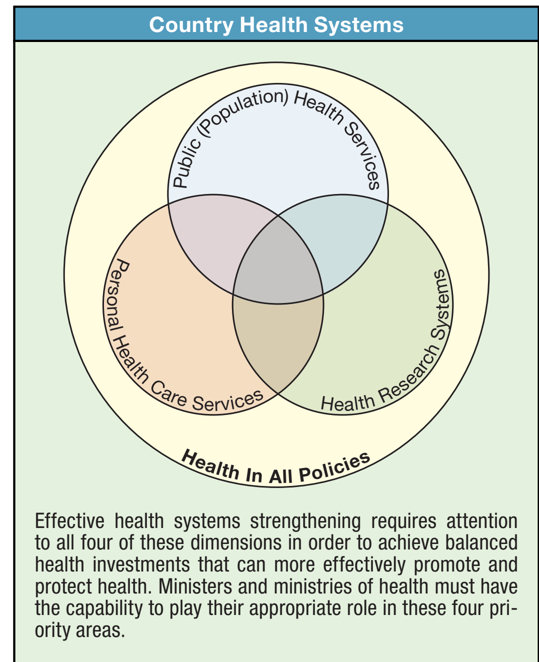
- a comprehensive literature review of the theory and practice of effective leadership development and organizational capacity building;
- an environmental scan to identify current leadership development programs for ministers of health;
- a review of the turnover of ministers of health;
- a mid-term consultative meeting of experts and stakeholders;
- participation of the project leaders in relevant global, regional, and individual meetings to discuss the study with international and donor organizations and potential champions of this effort; and
- a consultation with African regional health leaders to discuss the final report.

See Appendixes A through F of the full report for more detailed information on the minister and stakeholder questionnaires, study methods, and tabulated results.

The Language of Health Systems

What is a "health system"?

With increasing recognition of the importance of health systems to achieving a variety of health goals at country and global levels, multiple definitions of health systems have emerged. Many definitions have centered on the elements of a framework to deliver effective personal health care services as the essence of " health systems", while there have been other, less visible and often quite separate initiatives, focusing on the systems needed to deliver effective population (public) health services, health research, and healthy policy. As part of its Framework for Action, *Strengthening Health Systems to Improve Health Outcomes,* WHO has defined six building blocks of a health system: health service delivery; the health workforce; health information systems; medical products, vaccines and technologies; health financing; and leadership and governance.



Effective health systems strengthening requires attention to all four of these dimensions in order to achieve balanced health investments that can more effectively promote and protect health. Ministers and ministries of health must have the capability to play their appropriate role in these four priority areas.

In order to strengthen country ministries of health and develop the necessary capacities in the ministry and/or affiliated organizations, it is important to have an agreed definition of a health system. For the purposes of this report, a **health system** is defined as consisting of four core elements:

- **personal health care services,**
- **public health (sometimes called population health) services,**
- **health research systems, and**
- **health in all policies.**

To assure a balanced strategy for achieving the greatest health result in a country, all of these elements should be in place, and appropriately supported.

Personal health care services

When most people hear the term "health systems" they think of the professionals, providers and payers that deliver personal health care services. *Universal coverage* of the population is usually limited to assuring financial access to this basic personal health care. WHO has suggested the concept of a "basic package" of personal health care services *(benefits)* that countries can adapt to their resource availability. The promotion of a primary care approach begins to integrate attention to the personal and population health services within health systems. In the World Health Report 2008, *Primary Health Care (Now More Than Ever),* WHO identifies a set of primary health care reforms needed to refocus health systems towards health for all. These include universal coverage, service delivery reforms to make health systems people centered; public policies that promote and protect the health of communities; and leadership reforms to make health authorities more reliable. Specific elements of "people-centered primary care" include: focusing on health needs; creating enduring long term relationships; comprehensive, continuous and person-centered care; responsibility for the health of all in the community along the life cycle, including tackling determinants of ill health; and partnerships with the people in managing their own health and that of the community.

> *In LICs, 70 to 80 % of the disease burden is attributable to preventable infectious diseases for which the most effective intervention is public health action.*

Public (population) health services

While access to care is essential, personal health care services are only one component of an effective health system. Depending on the country, 70 to 90% of avoidable mortality is actually due to:

- risky behaviors (a combination of lack of basic sanitary infrastructure and/or the lack of public awareness of healthy choices, or conditions in which healthy choices are not available);
- factors in the built and natural environment; and
- genetic determinants of health.

In LICs, 70 to 80 % of the disease burden is attributable to preventable infectious diseases for which the most effective intervention is public health action. Despite this, less than 10% of national health expenditures (less than 3% in the US) are invested in public population health services (according to national health accounts data). Such services include the organizations, information systems, laboratories, and workforce who are often (but not always) part of governmental health agencies, and which have the ultimate responsibility to assure the conditions that provide the best opportunity for people to be as healthy as they can be.

Essential Public Health Functions (PAHO/WHO) [3] **A**
1. Monitoring, evaluation, and analysis of health status
2. Surveillance, research, and control of the risks and threats to public health
3. Health promotion
4. Social participation in health
5. Development of policies and institutional capacity for public health planning and management
6. Strengthening of public health regulation and enforcement capacity
7. Evaluation and promotion of equitable access to necessary health services
8. Human resources development and training in public health
9. Quality assurance in personal and population-based health services
10. Research in public health
11. Reduction of the impact of emergencies and disasters on health

PAHO and WHO, in collaboration with regional ministers, have also identified an equivalent basic package of public health services, a set of eleven *Essential Public Health Functions* that ministries of health should be able to provide to assure population level health (see Box A).[3] Forty-one countries in the Americas region have applied a self-assessment tool to determine the specific capabilities of their ministries to deliver on these eleven functions, and have begun to take action to address problems identified. "Universal coverage" priorities should also assure that these functions are available to all the inhabitants of a country as part of a health system.

Health research systems

National health research systems are essential to ensure an evidence base for the policies and interventions that are selected as priorities for the personal care, population health, and health policies that guide the health system. The 1990 *Commission Report on Health Research for Development* called for donor countries to earmark 5% of their official development assistance (ODA) for health research, and for LICs to target 2% of national health expenditures for research. Health research systems would include national plans, capacity assessment, identification of training needs, and strategies to create demand for evidence lead by country priorities. The Council on Health Research for Development (COHRED) was subsequently created to support country efforts to strengthen their research expertise, and has published guidance on developing country health research systems (see Box B).[4]

National Health Research System (NHRS) Development Components[4] **B**
The socio-political environment
• High level government support and strong leadership across all ministries is essential
The foundations of a NHRS
• Governance and management bodies – provide the structures to set objectives (e.g. government departments, research councils, committees, academies of science) and assure that objectives are executed, monitored, and evaluated
• Health research policy framework – the legislative/policy structure within which health research operates
• Health research priorities – country-based needs that are rigorously defined, regularly reviewed, and endorsed by the government/MOH, enabling researcher and funders to align with national priorities
Initial policy goals – after establishment of basic governance and policy infrastructure
• Human Resources – to conduct the established research agenda
• Sustainable funding – to build research capacity and commission work
Optimizing the health research system – additional policy goals once a NHRS is established
• Effective use of research results
• Research ethics review
• Monitoring and evaluation of research production and use
• Enhancing the research environment
• Developing the research culture
• Technology transfer
Integrating the system
• National systems and policies – e.g. the health system; the science, technology, and innovation system; national development plans for poverty reduction and health sector reform
• International systems and collaborations – with universities; research sponsors; bilateral, regional, and multilateral agencies; and foundations

Health in all policies

Finally, an effective health system is only possible in a political and policy environment that aligns government and non-government stakeholders to act for health. This is the concept of "health in all policies" in which governments accept health as a shared goal and make a commitment to a systematic review of all policies for their potential health impact (see Box C).[5] Active leadership by heads of country governments and an enabling global policy environment are critical. The European Union is one region that is currently implementing this concept.

[3] PAHO/WHO. What are the Essential Public Health Functions (EPHF)? Online at http://www.paho.org/english/dpm/shd/hp/EPHF.htm
[4] Adapted from Council on Health Research for Development (www.cohred.org)

A Health in All Policies approach recognizes that: [5]	C
• the health and wellbeing of all citizens is essential for overall social and economic development;	
• health is an outcome of a wide range of factors (e.g. changes to the natural, built, social, or work environments) many of which are outside the purview of the health sector, necessitating a shared responsibility and integrated response;	
• all government policies can have an impact (positive or negative) on the determinants of health for both current and future generations;	
• the impacts of health determinants are not equally distributed among population groups and disparities in health must be addresses;	
• efforts to improve the health of the population require sustainable mechanisms that support collaborative government agency work to develop integrated solutions;	
• many of the most pressing health issues require long term budgetary commitments and creative funding approaches;	
• indicators of success will emerge over the long term and intermediate outcome measures will need to be established.	

Stewardship and governance: related, but not the same

Though often used interchangeably, stewardship and governance are complementary, but not the same. To paraphrase an Oxford dictionary definition, a ***steward*** is ***one who is entrusted with the management of things belonging to another,*** or acts as a supervisor or administrator of the finances or property for another or others. This nicely describes the role of government as protector of the public interest and, in a unique sense not applicable to non-governmental entities, as responsible to the public for its actions. In matters of health, most international agreements assume that governments have the ultimate responsibility for assuring conditions that allow people to be as healthy as they can be. Health ministries and the ministers who lead them must be able to perform a variety of functions critical to an effective government role as stewards of health resources and health systems.

As recently reviewed in a report of the WHO Commission on Social Determinants of Health, "Closing the Gap in a Generation", there are multiple determinants of health, and it is clear that to be an effective steward of health resources, a ministry of health must do more than simply deliver care. It must work effectively across government to advocate health in all policies—with ministries of finance for resources; with ministries of education on health professions training and health education in schools; and with ministries of economic development, agriculture, environment, housing, and transportation. The ministry of health must also work with those ministries effecting decisions on centralization and decentralization of government and civil service reform, and with parliament to gain political support for health policies. In some countries, ministries must also relate to specialized parastatal agencies that are often created to perform government functions such as those that regulate drug quality, conduct and commission research, perform disease surveillance functions, and operate health care services, among others.

To be an effective steward of health resources, a ministry of health must do more than deliver care.

In this complex environment, government cannot meet its responsibilities alone, and health ministries must also work effectively with an increasing number of non-governmental actors — civil society, business, professional associations, academia, donors, academies of medicine and science, the public, and with regional and international organizations. The expanded number of actors that must be involved in assuring conditions for health has led to the increasing use of the term ***governance.*** There are multiple definitions of this term but most reflect, at the simplest level, ***the alignment of multiple actors and interests to promote collective action towards an agreed upon goal.*** As a good steward, a ministry of health must be able to lead and participate in effective systems of governance to assure the best use of resources for health.

A ministry of health must be able to lead and participate in effective systems of governance to assure the best use of resources for health.

Though there are evolving international standards for effective government, "governance" is almost always context specific, because it must reflect the ways in which all stakeholders interact with one another in a particular set of societal circumstances in order to influence the outcomes of public policies. Therefore, of necessity, actions needed to strengthen leadership and management for this increasingly complex role will vary from country to country.

[5]. Adapted from Kickbusch I, et al. Adelaide revisited: from healthy public policy to Health in All Policies. Health Promot Int. 2008 23:1-4.

Strategies for Health System Development Must Be Country-specific

Experts consulted in the course of this project cautioned that the global view of what *should be* in the four core areas of health systems is different from the reality on the ground. Country health leaders, especially in LICs, have to deal with variable resources, competing priorities, and multiple models being imposed from outside as conditions for financial assistance. Countries may find that they are less and less able to make their own decisions about the elements in their health systems. Over the course of the study, it was frequently noted that countries that have achieved “good health at low cost” often stayed the course on their own reforms, regardless of outside pressures. In Africa, it has been pointed out that it is countries with strong governments that are making the most progress, as they are better able to set their own priorities, marshal in-country partners, and steward external support.

It is critical to understand the country context in which health systems transformation must occur.

Thus, to support effective efforts to strengthen the *stewardship* and *governance* of health systems, it is critical to understand the country context in which health systems transformation must occur. The triggers that spark change and transformation in health systems are singularly country specific, and heavily influenced by history, culture, and social forces. In some countries, change is ushered in by new political movements, including revolutions, possibly following periods of prolonged conflict. In others, newly elected governments come with manifestos to fulfill. Change may be fueled and led by strong and visionary professionals and professional associations, working with civil society and transient political leaders. Sometimes it is a coincidental convergence within the ministry of health, of progressive and enlightened political and technical leaders, and in other cases, external influences are the prime triggers for the reforms. A recurring theme throughout the project was that, while health policy reform and leadership is both political and technical, it is the political environment that is the predominant determinant of outcome, especially the support of the political heads of government, and the social and political capital that stands to be lost or gained through tackling health systems change.

Decentralization: forging a common vision at all levels

A significant challenge for leadership and management of health systems, especially across Africa and for LICs, is governmental decentralization. The capacities that need to be strengthened for effective implementation of decentralization are diverse and involve not only leadership, but also the adequacy of structural, organizational, and human resources.

UN agencies and country governments are making significant investments in capacity building programs for public sector officials that bring together multiple stakeholders.

However, almost none of these have involved the health sector or its leadership, even though they are quite relevant to the broadly defined goals of health systems reform and transformation.

The demand for democracy is moving beyond the vote, to embrace issues of citizens’ participation in development planning, service delivery, public accounting, and budgetary management. This paradigm shift in the practice of democratic governance especially at local levels, has created a strong need for capacity in terms of knowledge, skills, attitudes, networks, and institutional and structural arrangements that are capable of supporting and sustaining engagement of citizens and action for local level development. But it must be emphasized that effective decentralization can only succeed when all actors (central and local governments, civil society, private sector, and international development partners) have the same vision and commitment, as well as required capacities. UN agencies and country governments are making significant investments in capacity building programs for public sector officials that bring together multiple stakeholders. However, almost none of these have involved the health sector or its leadership, even though they are quite relevant to the broadly defined goals of health systems reform and transformation.

Health ministers at the center: facing an unsupported mandate

Wherever the leadership for coordinating health system reform is located, whether in a dedicated unit in the ministry of health, or assigned to another agency in government, in most cases the prime responsibility for articulating, championing, advocating, and ensuring successful adoption and implementation of health policies ultimately rests with the ministries of health. Yet ministries of health and other social services went through a damaging period when they were classified by

macro-economists as nonproductive sectors, only consuming resources and not contributing to national economic growth. The status and influence of health ministers and ministries declined within cabinets and parliaments, along with their bargaining power for resources. Because the effectiveness of individual leaders is closely related to the availability of institutional support for their efforts, ministers, particularly those in low-income countries, have great difficulty implementing programs and policies that could impact the health of their populations or contribute to global health.

A challenge in many LICs will be changing the mind-set of ministries from "powerlessness" to a "can-do attitude".

In recent years, the catastrophic drop in life expectancy in many Sub-Saharan African countries, the aggressive activism of the HIV lobby, and the strong movements for social justice, equity, human rights, and poverty reduction, have all contributed to putting health back in its rightful place as a basic human right. Health is an essential input, as well as a consequence, of social and economic development and is now part of many national constitutions. The importance of health can be seen in: the global drive to fulfill the Millennium Declaration and the MDGs, all of which are health related; the personal interest of the UN Secretary General in global health; and the consistent emergence of health as a key agenda item in recent G8 and regional political summits. The increasing attention to health is also evidenced by the huge increase in resources allocated globally to countries through agencies such as the Global Fund, GAVI, and a plethora of other new financing mechanisms, as well as the growth of civil society with strong health advocacy interests driven internationally and locally. Yet historical paradigms have left ministries of health relatively under-resourced and "low-power" within governments. A critical challenge in many LICs will involve changing the mind-set of ministries from "powerlessness" to a "can-do attitude" in shaping a health system that reflects their priorities. There is a movement among key development partners to forge partnership strategies that allow countries to lead decision-making; institutionalizing mechanisms and capacities and empowering governments to undertake oversight functions for the public and private sectors. Effective ministries of health will be key to realizing these opportunities.

Understanding the Needs: Minister and Stakeholder Perspectives

Twenty-four ministers and former ministers of health (referred to here collectively as "ministers") were interviewed regarding their prior experience, qualifications, length of service, how or why they were selected for the ministerial position, and their responsibility and challenges. Interviews were also conducted with 20 high-level stakeholders who interact directly with ministers, including senior civil servants, parliamentarians, academics, donors, leaders of international organizations, and global organizations of civil society.

MOH Experience*	N = 24
Health-Related Experience	**15**
Physician	12
Political Experience	**14**
Ministry Experience	3
MOH Experience	1
Party Activist	9
Community Activist	5
Academic	**3**
Managerial	**3**
Recruited by President/Prime Minister	**19**
Years Served Average (range)	3.9 (.5-10)

**Multiple response were permitted*

The backgrounds of ministers of health are diverse

The ministers interviewed came from a variety of backgrounds and experiences ranging from decades of health-related policy, programmatic, managerial, community and clinical experience, to seemingly minimal relevant background or preparation. Several noted years of service in political parties, as community activists, or as freedom fighters.

Key findings:

- 60% reported previous health-related experience (50% were trained as physicians)
- 56% reported having previous political experience (4 had prior ministry level experience, including 1 who had previously been MOH)
- 76% reported that they were recruited to the post by the president or prime minister, in some cases because of previous personal friendships
- 3.9 years was the average tenure of those interviewed

Political experience vs. health expertise

A number of ministers, but certainly not all, expressed concerns about their qualifications and personal preparation. Of those ministers coming in with significantly less experience there was a split between those who felt competent and those who did not. In particular, ministers without health training felt that their limited understanding of content impeded their ability to effectively execute the responsibilities of the job.

Ministers without health training felt limited in their ability to effectively execute their responsibilities -in contrast- Stakeholders were concerned that ministers lacking political skills might have a more limited and less strategic vision

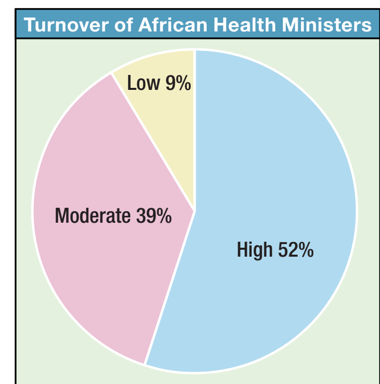
In contrast, stakeholders emphasized the significant political responsibilities of ministers of health, and were critical of selection criteria that over-emphasized clinical experience. Stakeholders often felt that while familiarity with health issues was a plus, those lacking political skills might have a more limited and less strategic vision. Clinicians were felt to focus on medical solutions, for example on building hospitals, rather than on policy or developing primary health care systems. Several noted that physicians with a public health background (vs. a predominantly clinical background) were more aware of the need to work with other ministries, international partners, the business sector, and civil society, all of which can play key roles in the implementation of health programming.

Limited orientation

None of the ministers reported having received any formal orientation on first taking the position. Six specifically remarked on the absence of any briefing, noting difficulties faced as a consequence of the lack of information. Basic information was considered to be a real need by those with limited prior experience, as well as by those with more relevant experience. Stakeholders reinforced this need, and saw new ministers as "overwhelmed" with emergencies that overshadowed basic operational responsibilities of the ministries, including health systems planning and strengthening.

Limited tenure

A particular concern for ministries of health is consistency or continuity of leadership. As noted above, the length of service of the ministers and former ministers interviewed ranged from six months to ten years, with the average tenure being 3.9 years. An internet search conducted to further assess the turnover of ministers of health in Africa revealed that of 23 countries sampled, only 9% were considered to have low turnover, averaging 2 ministers during a 10-year period (1998-2008). Moderate turnover occurred in 39%, averaging 3 ministers over 10 years. Fifty-two percent had a high turnover rate, averaging between 4 and 5 ministers over the 10-year period, with some as high as 8 ministers during that time. Turnover on the Asian Subcontinent compared favorably to African countries, with many countries having an average turnover of 3 ministries over the same time period, however there were extreme cases of hyper-turnover in countries such as Nepal and Japan, with the former reporting 14 Ministers of Health between 1998-2008. (Further details can be found in Appendix D of the full report).



Ministers face a complex set of responsibilities and challenges

Ministers of health described a complex set of responsibilities and challenges that included:

- assessing health and service needs,
- securing resources
- identifying intervention strategies,
- development and implementation of health policy,
- promotion of health and health care services
- maintenance of the health infrastructure, and
- communicating and advocating for health.

"Being a health minister is tough in that it entails dealing with issues that one may have no control over." –MOH, Sub-Saharan Africa

"They have responsibility for the health of people but no means to carry that out." –Stakeholder, International Organization

As described by a stakeholder from Sub-Saharan Africa, the challenges inherent in the position are almost limitless.

Four of the ministers, mostly from middle-income countries, described their work within the context of an existing national health care reform plan. Objectives of those plans included enhancing equity, quality, and access, and emphasized shifting

from a disease focused system to one that promoted primary care, public health, and increased public awareness of healthy and unhealthy behaviors. One described implementing the third stage of a pre-existing 15-year plan for the health system.

All ministers interviewed noted significant challenges to fulfilling their responsibilities. These challenges reflected some combination of:

- high disease burdens (particularly in low income countries and southern Africa),
- limited financial and human resources,
- inadequate information systems, and
- partnerships that involve differentials in power and competing priorities.

"As we get in below the regional level, we can see that many of the organs in the Ministry are absent or atrophied, especially in relation to operations and the regulatory function. If it's a low resource country, they tend to be chronically underfunded for a whole variety of mandates. The problems are more visible in dealing with the underserved populations and in countries where there's high turnover both in the political system and within the Ministries. There is very little institutional memory. Many regions are still living with the legacy of the 80's where government was bad. This has not really been addressed and this ideology is undermining the important understanding of the key functions of government in assuring that they're appropriately built." –Stakeholder, International Organization

"We have lots of human resources, but they're poorly trained. Management in the ministry was virtually zero. Letters weren't answered – we had to get email for everybody and change the customs so they were more comfortable with electronic communications. Many staff had part-time jobs outside the ministry or their own private practices; so we had to figure out how to build this into their human resources contract so that it wouldn't be under the table." –FMOH

In the midst of so many competing demands, many ministers described *defining their own agenda* as a central leadership challenge. For some, this meant establishing their identity as separate or new compared to their predecessor; for others it meant identifying priorities. As noted above, many come into the job without relevant experience, training, or orientation. Lack of epidemiologic and other reliable data on population health status makes it difficult for an incoming minister to understand exactly what the health priorities should be. A good "situation analysis" of the country context was seen by a number of ministers as critical, but was often lacking (e.g. an understanding of public expectations; political commitment to health issues in general and the minister of health in particular; the tools and levers that ministers have to change the system; economic realities). In addition, the basic operational capabilities of ministries were often a challenge, exacerbated by policies of decentralization.

The global agenda: Millennium Development Goals

Only two ministers explicitly mentioned Millennium Development Goals (MDGs) in response to questions about their challenges and priorities. Because of the global emphasis on MDGs, this low frequency was somewhat unexpected. However, further analysis of the data revealed that many of the challenges that were explicitly identified by ministers were covered within MDG categories (see Table). The continuing dominance of attention to infectious disease often reflects the availability of financial resources through global vertical programs.

Issues Cited By Ministers	MDG	N = 24
Infectious Diseases	MDG 6	15
Eradicating Extreme Hunger and Poverty	MDG 1	7
Primary Education	MGD 2	3
Child Mortality	MGD 4	3
Maternal Health	MGD 5	3

The national priority: strengthening country health systems

Like any successful enterprise, a strong health system is built upon a solid policy foundation; is appropriately supported, not just for maintenance of status quo, but also for growth; and is staffed by qualified individuals working in suitably equipped facilities.

Policy: sound health policy forms the foundation of a strong health system

In the broadest terms, ministers of health see themselves as responsible for national-level leadership in the health sector, which at its core involves development and implementation of health policy. These policy and leadership responsibilities were seen as a challenge by a number of ministers (n=10). Concerns included:

- health reform and the creation of new initiatives,
- translation of policy into action,
- maintaining priorities
- strengthening of the ministry's regulatory role, and
- engaging effectively with the private sector.

In countries that had implemented or were contemplating health sector decentralization, the leadership challenges at the national level were amplified.

> *"Most people see critical health as medical care, this includes both colleagues in government and the public. So it's very hard to mobilize other ministers and sectors as far as health and public policy is concerned." –Stakeholder, Academic*

Within the policy agenda, seven ministers noted that health promotion and disease prevention presented particular challenges, due to the traditional emphasis on direct medical services and development and maintenance of medical facilities. Specifically, ministers struggled to effectively disseminate health messages to positively influence the public's "value on health."

Resource mobilization: increasing the investment in health

Insufficient economic capacity –both resources and analytic capability– was mentioned as an explicit challenge by the majority of ministers responding (n=16) and was among the root causes of many other specific problems that they faced. Analytic weaknesses made it difficult to "make the case" for more resources or demonstrate the relative value of different priority investments. Lack of resources had direct implications, such as inadequate funds for infrastructure development and poorly trained personnel, as well as indirect implications, including the uncomfortable reliance on donor agencies and the need to compete with other governmental sectors for limited public funds.

> *"The budgets are weak. Ministers have responsibility for the health of people, but no means to carry that out. There's weak management and ministers are often absent from donor meetings. Many ministers feel insecure and resist working with other sectors, so they're not smart at developing strategic alliances for budget advocacy within their own governments." – Stakeholder, International Organization*

Human resources: training and retaining health workers and ministry staff

Issues related to the training and size of the health work force permeated nearly all of the interviews (n=22). There was an overwhelming need for additional "human resources for health." This included the need for more and better qualified health care personnel (n=15); new cadres of health workers; and better alignment of health system and health professions education. Once trained, retention challenges cited included low salaries, poor working environments, and frequent turnover, as well as the need to increase the management and leadership capacity within the health service system, including that of ministry staff (n=12).

Several ministers from LICs also noted the need to build the technical capacity of ministry staff to move beyond planning (n=4); be able to collect and analyze data for policy analysis (n=5); and define standards and implement and measure them (n=4). The lack of civil services reforms and absence of staff development was also noted by several ministers (n=7).

Infrastructure: building the operational elements of a strong system

Deficiencies in the health infrastructure, including health facilities, laboratories, pharmaceuticals, supplies and equipment, transport, and information systems, represented a significant challenge to a number of ministers (n=11). As would be anticipated, infrastructure was particularly problematic in countries facing political or social crises, including political unrest, war, and international sanctions.

> *"We were left with no public health laboratory, no primary care centers and no functioning hospitals, so renovating infrastructure was a major challenge." –FMOH*
>
> *"My job was to implement and develop a policy on coverage for the prices of medicines and surveillance systems. But… the data gap was a big problem." —FMOH*
>
> *"There was a struggle to get basic data to develop reliable vital statistics in real time and to get real reports that could give us the evidence for practical advocacy." –FMOH*

The implications of inadequate health and information management systems for planning, advocacy, and oversight were articulated in several minister and stakeholder interviews.

Not surprisingly, ministers of health from higher income countries were more likely to describe achievements, rather than deficits, in infrastructure.

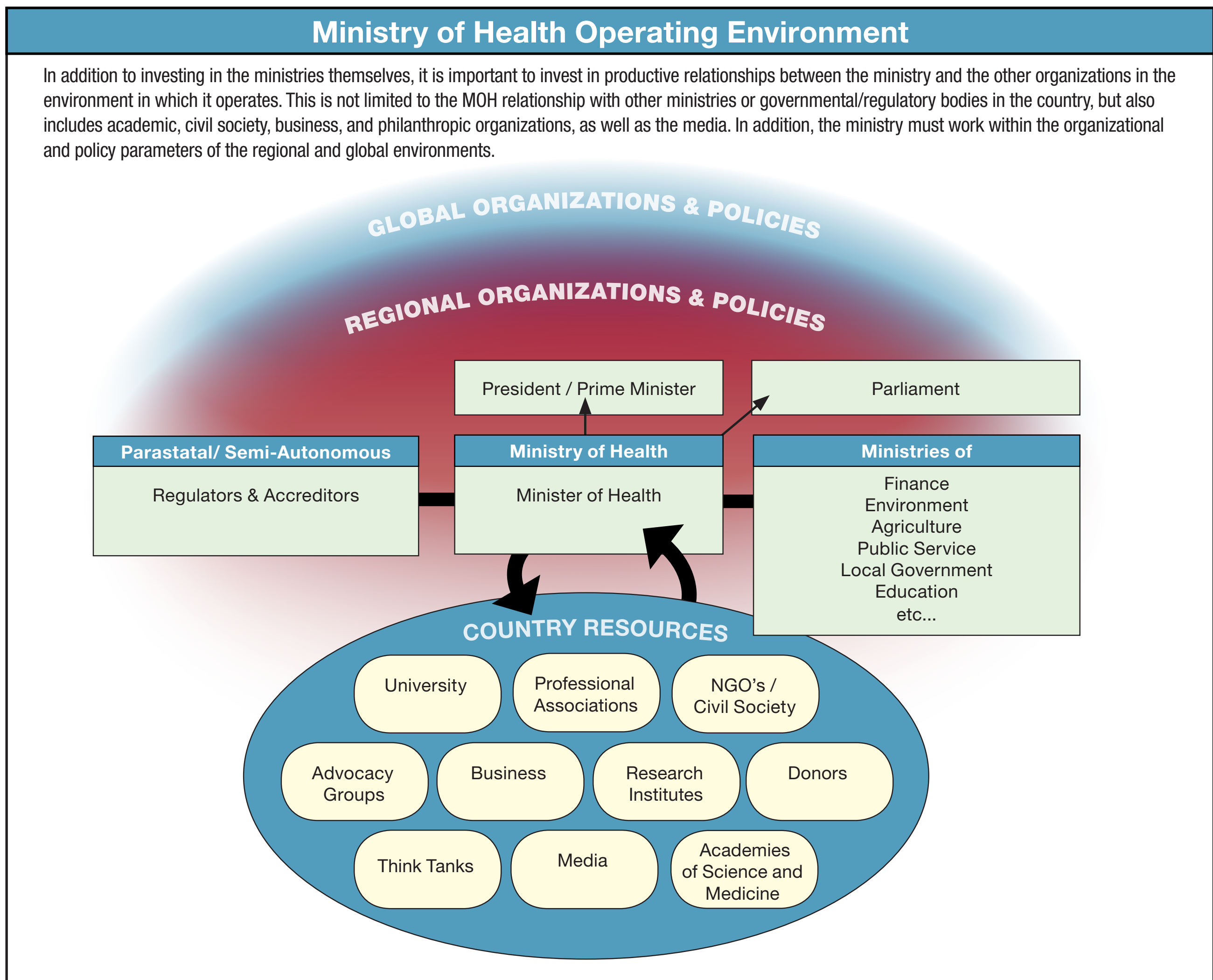
Forging relationships with other organizations

Only about a third of the ministers (n=8) identified "political leadership" with other organizations as a principal responsibility of ministers of health. As noted above, this relatively small number may reinforce the need for greater orientation to the political role in selection and orientation of new ministers. Incorporated within the concept of leadership, when identified, were:

- parliamentary responsibilities;
- effective advocacy and partnering with other ministries, civil society organizations, and the business sector;
- donor management within country; and
- work with international agencies, and global and regional technical and development organizations.

> *Among the greatest of ministerial challenges … ministers of health must regularly advocate and negotiate for funding and other support.*

In order to provide the programs and services needed to promote the health of the public, ministers of health must regularly advocate and negotiate for funding and other support. This negotiation and advocacy was a common theme across the interviews, especially those of former ministers and stakeholders, and was considered to be among the greatest of ministerial challenges. Potential partners often have conflicting social and fiscal priorities and, particularly if they have access to funding, retain greater power than the minister and ministry. The challenges of negotiating with these partners are compounded by gaps in information necessary for identifying health service needs, developing appropriate plans, preparing evidence-based funding requests, and reporting to stakeholders.



Relationships across government: the Ministry of Health is first and foremost a government agency

Numerous ministers (n=21) emphasized the challenges that exist within the government system, including the need to convince presidents or prime ministers, ministries of finance, parliaments, and other national and local leaders of the importance of health-related funding. In low resource countries, the difficulties of this task are amplified by a lack of appreciation for health needs within other branches of government, and resistance to prioritizing health activities, particularly if the costs are high. Decentralization of health funding adds another level of difficulty for the federal minister.

> *"Great challenges of the ministers are to develop a persuasive argument for the Ministers of Finance, to increased the percentage investment of the GDP in health…to attend to equity, quality and financial protection as part of health reform….In the ministry, there was a strong technical group in the public health core, but not in financing economics and so we created an economic analysis unit that reported directly to the Minister and was able to change the terms of dialogue with the Ministry of Finance. There was very little mileage in the moral argument, but some analytics in the language of the Ministry of Finance were much more effective." —FMOH*

Several of the ministers described the processes they developed for intra-governmental advocacy and negotiations. Some ministers (more likely in MICs) noted the value of supportive governance structures above the ministry, including structures to coordinate clusters of ministries such as health, education, social and economic development, or the practice of holding regular cabinet meetings, but the existence of these or other kinds of supports was rarely noted. This indicates the challenge of creating mechanisms to support a "health in all policies" process. Successful cross-government convening will largely depend on the commitment of the president or prime minister.

> *"The MOH needs to be well connected in the cabinet and know how to relate to colleagues, especially the Prime Minister and other officials who are key to getting the money to make decisions. So relating to the inner cabinet is crucial. The minister needs to understand where and when decisions are being made about resources and priorities so that s/he can be there. He or she needs to understand domestic resources and foreign resources and the relative value and advantages of each. The local government may not even care if the health function is done effectively as long as they get the money." —Stakeholders, international organization*
>
> *"When I came in, I had to establish a close personal relationship with the president. I saw him on weekends, had in a sense, a contract of sorts. The president was attracted to that idea, yet he's very focused on accountability, and he could help me with every minister who wouldn't cooperate on joint projects. I think with training, any minister of health could do this. Any president would welcome it." —FMOH*

Relationships with civil society organizations

Engagement of civil society, including non-governmental organizations, unions, and professional associations, was identified (n=15) as having the potential to contribute to political and health changes such as the development and implementation of health programming and promotion of recommended policy. Ministers' specific reports of relationships with some civil society organizations were mixed, however.

In most low-income countries, civil society organizations tend to be either service providers or advocates, so they largely relate to the ministries on their own issues. The challenge is developing a civil society capacity for more general advocacy for health and the ability to hold government accountable for delivering on a more comprehensive health agenda.

> *"The health professional associations were the most powerful asset and totally underutilized. If they're with you, they can be enormously effective, because they cut across all sectors, public and private and have a lot of influence on priority setting." –FMOH*
>
> *"They [professional organizations] resist integration and change in the health system." –MOH*
>
> *"All of the non-profits in health have a memorandum of understanding with the Ministry of Health and are committed to addressing the strategic plan within the government framework. They decide what they're going to work on and we support and monitor their activities." –MOH*

Relationships with business: public-private partnerships

The business sector, including independent medical providers, pharmaceutical companies, pharmacies, employers, and insurers represented another set of relationships to manage. Sometimes considered to have "little interest in health," but to be more focused on the business interests of their particular company in the health care enterprise, they were in fact, helpful to some ministers (n=8) to increase access to needed services and resources. Most ministers felt concerted effort had the potential to lead to more effective collaborations.

Stakeholders noted that the business community might assist ministries with expertise on contracting, financial management, institutional management, and staff training, tapping into both in-country and global infrastructures, but there was limited evidence of this actually happening.

About 20% of ministers reported little or no collaborations with the business sector; some of this was in countries where the business sector had been weakened by political strife and there was little opportunity for effective collaboration. There were examples of different ministers from the same country having different attitudes and relationships with business, so the lack of links to business in some countries may be more individual than structural.

Sixty-percent of the cost of health care is paid on a fee-for-service basis. In my country, there are lots of private entrepreneurs in the countryside, and medicine is practically like food. But the private sector's role is in the service sector, how they can be contracted for support of the public sector? This was the major focus of my time at the ministry. I went to a mining company and asked them to expand care from their employees to the families and communities in their original area and assist with medical stores, training staff, and with product flow." —FMOH

Within the bounds of public policy, we encourage investment in facilities and pharmaceuticals; we regulate the private sector—they are more aggressive, but we control them." —MOH

A challenge is bringing business in to work effectively with the State. We created public private partnerships to maximize consumer participation, but this is difficult because there's no experience of the public being consumers, making demands from their point of view. There is also community activity trying to help them learn how to organize themselves, but in these early stages, it's quite conflictual. You just have to listen to their different points of view." —MOH

Relationships with donors: gaining support while maintaining autonomy

Although donors are predominantly from outside the country, the minister's role in managing these relationships is one of the major "in-country" challenges. On the subject of donors, sixteen ministers discussed global health initiatives and fewer discussed bilateral donors (7) and foundations (6), though when asked to characterize their relationships with donors on a scale from 1 (work closely together) to 5 (no relationship), bilateral donors were ranked 1, followed by foundations (1.5) and global health initiatives (1.9). In contrast to their relationships to national partners, where the focus is often to "make a case for health," most outside donors were described as having an explicit interest in the health outcomes of specific populations, tackling specific diseases, and more recently, health system strengthening, including health workforce.

"The donor staff at the country level was often weak. They wasted money on diseases versus dealing with the health system. They talk a good game, but on the ground don't follow-up and certainly don't work consistently toward the country's goals." -FMOH

"Another major challenge was donor management. Eighty percent of the ministry's budget is from overseas development aid, and [these donors] were essentially partitioning the country according to their interests, fighting among themselves to protect their area and not often cooperating with the Ministry of Health. So the big challenge was how to convene and get them to adhere to our plan." –FMOH

Challenges inherent in these collaborations, therefore, differed from those experienced with in-country collaborators, although they loomed large. Depending on the donor organization, these may include:

- rigidity in programming, and priorities that are inconsistent with country priorities;
- donor staff inadequacies, including low levels of cultural competency and lack of knowledge regarding local conditions;
- disproportionate power; and
- inadequate resources.

Collaborations with donors are demanding, but when they work well they are highly valued.

"We have inputs in the form of resources to increase the training as well as support from our bilateral and multilateral partners such as the Global Fund and the Clinton Foundation. They are available regionally and internationally. They are very helpful because we have been assisted to strengthen our health system and to train more personnel." – MOH

"Our HIV/TB/Malaria funding programs work well. We have a government body that coordinates donors and there is a consultative body that meets annually with technical working groups between the government and the donors." –MOH

"Cooperation with GAVI, the program, is vertical but the money does go to the Ministry of Health, so you can control it. At the time it was not funding systems and this was a problem. This is now changed and they are good to work with." –FMOH

Negotiation and sustained authority (even if partial) also was possible, though challenging.

"(global program) came in and disrupted our integrated plan, but eventually we overcame this and negotiated. Initially they went over the heads of the ministry to the president and the Prime Minister, threatening him until he cooperated… The Minister of Foreign Affairs helped us intervene … and our approach became a template for other African countries." –FMOH

"The (global program) initiated this quite prescriptive approach, wanting us to do things their way with controls, a country coordinating mechanism and third-party oversight. They wanted a separate program; we refused...I went to the president's office and they finally agreed to negotiate with us and they eventually came around." –FMOH

Stakeholder perceptions of donor relations were consistent with those of ministers, emphasizing the inequality in power and the need for great political savvy of governmental leaders to maintain some level of autonomy and better control the agenda.

"The donors keep asking do we know what the ministries want, but the African Ministers have expressed themselves many times, but others come in with their own initiatives from the outside and challenge these frameworks." –Stakeholder"

"(The) minister of finance indicated that 90% of his external donor money went to HIV when the incidence in (country) was only 4%. Though they're 17th in the world in maternal mortality, they weren't able to get funds for that. Therefore, what do they do? The country spends the money on what it's allocated for. There are not any functional international accords of donor behavior in spite of all of the rhetoric." -Stakeholder"

Relationships with organizations to build ministry expertise

There are a variety of other institutions in the country that could provide important intellectual support to the work of the ministry. Unfortunately, these organizations are often faced with the same overall resource constraints and conflicting priorities that generally limit the ministry's capabilities. Universities are common partners; however they often have limited expertise in areas such as health services, health policy, and health economics research, areas that are critical for providing evidence for action by the ministry. At this time, few LICs have independent health policy think tanks. Ministers who completed a more detailed questionnaire on the nature of their interaction with non-governmental partners (n=14) reported working most closely with national NGOs, followed by academia. Relationships with businesses were considerably more distant. Efforts

to strengthen national academies of medicine and science as providers of expert advice on health and science policy are limited, but several African countries are making strides in this area. Demand must be created among policy makers and politicians to foster an environment where evidence-based initiatives become the norm.

The many roles of academia: educating the workforce, sharing data and expertise

Most ministers (n=16) described academia (national and overseas) as providing essential support in education of the health workforce, including both ministry and community-based personnel. Academic institutions can also provide access to and analysis of data, technical training, general human resources development, and specific health program development. Few ministers (n=3) described the relationship with academia as either not helpful or nonexistent. The ministry-academic partnerships seemed particularly strong in middle income countries.

While a key resource, these collaborations were also described as complicated by the fact that academic institutions, and their faculty, may have divergent interests and priorities that are sometimes disconnected from specific country health needs. Alternatively, they may be strong in traditional infectious disease research areas long supported by global funding institutions, but weak in health services and health policy research capabilities. More likely, however in many LICs, the academic sector like the health sector is under-resourced. Faculty members often have multiple jobs due to the low pay in the university, leaving them little time to focus on public concerns. All of these factors make timely responses to ministry needs difficult.

We've really built the health system together. The university role was to think critically about the issues and the health service; they've been very generous with their resources.…We are now working on building a school of health governance with a local campus that would represent a consortium among 12 Latin American countries. This would focus on creating managers of health and foreign affairs, education and planning, with a health sensibility. There would be both short and long term courses as well as undergraduate and graduate certificates. –FMOH

Relations with universities are good but slow in their decision making. They're weak in health services research and health policy research, although now those fields are increasing with younger professionals. –MOH

There's not enough emphasis on research in lower-income countries, so it's hard to get information on what works and doesn't work. The real need is for academic research and clinical and operational research. If that were easily accessible, it would be helpful. Creating a virtual observatory that could be broadly accessible to government and the public would be invaluable. And most useful would be resources, or a place to discuss best practices with in-depth case studies comparing what we're doing and successes we have had. –FMOH

Although most references to academia focused on in-country facilities, overseas resources were used and valued as well.

They helped us a lot; both local and academics from the global north can be very helpful in developing countries. There needs to be a resource center that can help us network and identify what's best suited for our needs. We are building skills for everyone not just providing advanced degrees. We would also like to see academics enlisted in steering research in health policy, health services research, and creating centers of excellence in areas needed by the Ministries to improve the health system. –FMOH

Expressing an alternative view, one stakeholder described a perceived government preference for using overseas rather than internal academic resources, so as not to seem weak.

For political reasons they may not wish to be seen as using local people. For solutions, they often bring in special advisors or expert consultants who really have no good knowledge of the context. Ministries need to be capable of drawing advice from wherever it's helpful and be assured that it's okay to do so. Sometimes they don't know what they have in the ministry and what's available in the country. —Stakeholder, Academic

Regional organizations allow for peer interaction, sharing of ideas

Though many regional organizations are primarily economic in nature, they are increasingly addressing health issues, and are seen as being a potential locus for more structured interactions among ministers within particular regions, and for raising the political visibility and understanding of health issues among regional heads of state. The African Union Commission is increasingly taking on health and social issues. Regional organizations may also be platforms for securing resources for countries and cross-national collaborations.

Multilateral institutions as sources of medical, technical, and policy guidance

All ministers discussed the importance of collaborations with global organizations. Ministers (especially those in LICs) reported receiving guidelines for care, training, technical and financial support, general advice, and (at times) help in framing policy from UN and other multilateral agencies.

As with donor organizations, however, ministers also reported challenges working with these agencies. In addition, some were faulted for being wasteful, dictatorial, and ignorant of regional and country perspectives. When asked to rank the nature of their contact with these organizations on the same 1-5 scale, WHO was ranked 1, followed by UNICEF (1.2), and UNFPA and UNDP (1.6), with much more distant relationships occurring with the World Bank (2.4) and WTO (3.1). One minister noted that if the ministry staff is not strong, one may not get the best results from international organizations.

The UN system is the most consistent and is always there, with or without economic sanctions. -FMOH

Interactions Inside and Outside Government

Ministers were asked to rate how often they interacted with the following individuals or organizations.
Scale: 1=Work Closely Together, 2=Use as Advisors, 3=Consult Occasionally, 4-Inform as Needed, 5=No Relationship.

Sector	Mean Score (N=14)
Within the Ministry	
Permanent Secretary	1.00
Director of Health Services	1.38
Specific Program Directors	2.31
Within Government (Outside Ministry)	
President	1.50
Prime Minister	1.64
Other Cabinet: Finance Minister	1.86
Other Cabinet: Civil Service	2.00
Other Cabinet: Education	2.00
Parastatals	2.08
Other Cabinet: Economic Development	2.15
Other Cabinet: Environment	2.43
Parliamentarians	2.54
National (Outside Government)	
NGOs	1.86
Academia	2.00
Business	2.93

Sector	Mean Score (N=14)
Global Organizations	
WHO	1.07
UNICEF	1.21
UNFPA	1.57
UNDP	1.64
World Bank	2.36
UNEP	2.54
WTO	3.14
Donors	
Bilateral/ Government	1.07
Global Health Initiatives	1.53
Foundations	1.93
NGOs	2.25
Business	3.46

Taking action: Building a systematic and sustained program of support for health ministries

From the interviews and meetings with current ministers of health, former ministers, and other high level global health stakeholders, as well as from discussions of this initiative and its recommendations with experts and organizations that could be critical to moving this work forward, it is clear that:

- effective stewardship and governance of country health systems are fundamental to achieving national, regional, and global health goals, yet they have received little systematic attention in efforts toward health systems strengthening,
- ministers and ministries of health play a central role in the stewardship and governance processes, and are currently overlooked in investments and initiatives designed to strengthen health systems.

Ministries of health and the ministers of health who lead them must be able to:

- perform a set of core stewardship functions within the ministry and across government, and
- participate effectively in the governance of a network of strong country level institutions from within and outside government that can serve as resources to augment their expertise.

The majority of ministers and stakeholders agreed that the actions and objectives proposed herein to strengthen ministerial stewardship capacity are feasible and achievable within the more complex health systems strengthening agenda.

To successfully meet these objectives, the important role of ministries and their partners must be recognized, and a systematic and sustained program of support at country, regional, and global levels is needed to assure that ministries can fulfill their unique role — assuring the conditions in which their populations can be as healthy as they can be. This is achieved through effective stewardship and governance of all four elements of health systems: the personal health care delivery system, the population health services system, and the health research system, all supported by a policy environment that promotes health in all policies. Ministers and ministries must receive resources and long-term support from political leadership, the public, and the international community.

Based on the data from the interviews, literature review, consultations, and meetings over the duration of this project, and key consultations on the final report, the following recommendations can serve as core elements of a systematic and sustained program of support for health ministries.

Country-level actions

Though country needs will vary and specific strategies for action must therefore differ, there are universal functions that must be performed by or managed by ministries of health, in order to assure the conditions for the country's inhabitants to be as healthy as they can be. Ministries must fulfill the core functions of any public sector governmental entity, as well as those of the agency most responsible for health functions. There should be clear mechanisms of accountability for results from both sets of functions, and methods for public reporting and monitoring.

Strengthening ministries of health

Ministries of health, like all ministries, require certain critical kinds of staff expertise and infrastructure to perform their core policy and technical functions. In addition, ministries must be able to effectively work across sectors of government to advocate for health funding and promote health in all policies. They must also be able to work in various governance arrangements with donors, national and international civil society organizations, business, and academia through formal and informal partnerships, contracts, or other mechanisms of effective communication and collaboration. While many of these relationships center on addressing constituency needs and demands, there is also a need for partnerships with what this study has termed "Health Resource Partner Institutions" - organizations that have specific expertise needed to support and supplement the resources of the ministry in its core functions.

From the review of the literature, minister and stakeholder interviews, and discussions at consultative meetings, the following core governmental functions of ministries of health were identified relative to their role in providing stewardship and governance functions in any country:

1. policy making,
2. financing and resource mobilization,
3. standard setting and regulation of the public and private sectors,
4. collecting and disseminating information,
5. supporting research and training,
6. providing technical assistance and capacity building to other levels of government,
7. direct or contract management of selected activities, and
8. international liaison.

These core functions could apply equally to any governmental ministry for their particular area of focus. Examples of specific health-related activities in each category are provided in Appendix 2. The capacity in each area will vary depending on the country. Ministries in richer countries tend to be stronger in and emphasize the policy making, regulatory, and information collecting and sharing roles (the first four areas), while ministries in LICs tend to focus much of their work in direct management of research and training, technical assistance and capacity building, and in direct and/or contract management of programs and services (areas 5-7). Both have differentially defined and developed international liaison activities. The challenge is for the ministry to have, or be able to access from others, the resources to fulfill its core functions. As noted above, the stewardship and governance functions of ministries of health must include work with all four components of the health system: personal health care services, public (population) health services, health research, and health in all policies. These have been largely incorporated into the PAHO/WHO formulation of the *Essential Public Health Functions*[3] that are specifically focused on how these core functions of any ministry can be applied to a ministry of health.

To aid ministers, a needs assessment tool should be developed to "diagnose" the capacity of ministries of health to perform their core functions in the areas of stewardship and governance of health systems, including providing the Essential Public Health Functions. The results of such an assessment can be used to guide ministry investments and requests for support and expert assistance from their own governments, and from resource partners and external donors. In addition, existing UN public administration management development resources should be made available to the health sector.

RECOMMENDATION 1

Capacity Assessment Tools

Provide ministers and ministries of health with tools for determining their technical capacity to perform their core stewardship and governance functions for the health system (including the Essential Public Health Functions).

As the UN's leading health agency, WHO, through its regional leadership and collaboration with country experts, ministers and country health leaders, should facilitate development of a tool that permits countries to self assess (or participate in a regional peer review process) the stewardship and governance capacities of their ministries of health. This could most easily be based on the methodology developed by PAHO/WHO to evaluate ministerial capacity for providing the Essential Public Health Functions. Relevant methodology should be reviewed and appropriately adapted for use in all WHO regions. WHO should subsequently facilitate the assessment process at country-level. Results of assessments can serve as the basis for country action planning and mobilization of resources to address the gaps in capacity identified.

RECOMMENDATION 2

Leveraging Existing Leadership Development Resources

Consistent with the "One UN" agenda, existing programs for strengthening of public administration leadership and governance in the UN system should partner with WHO, and regional- and country-level governmental health agencies, to make resources and expertise readily available to them.

Since the founding of the UN, the development of public administration within countries has been one of its cornerstone programs. This program has included leadership and management development, the use of IT, and e-government, among other initiatives. These resources have rarely been made available to the health sector leadership within countries, however, in part due to fragmentation within the UN system, and the more technical program focus of WHO and the H-8 UN technical agencies involved with health. There is considerable interest in addressing this lack of connection to health within the UN agencies working to strengthen other areas of the public sector. The Office of the Secretary General of the United Nations should facilitate the linkage of the UNDESA Division for Public Administration and Development Management, and the UNDP Bureau of Public Policy and Governance, with the work of WHO and health-involved UN agencies on strengthening of health systems stewardship and governance at country level.

Building country networks of Health Resource Partner Institutions (HRPI)

Throughout the interviews, ministers and stakeholders noted the importance of organizations outside of government that can provide needed expertise and resources to ministries of health. Every country needs to cultivate and grow a critical mass of individuals, groups, and institutions that interact regularly among themselves and with their governments, parliaments, and civil society as agents of change, holding each other and their governments to account, as well as providing support. Networking among in-country players will be essential to promote cross learning and support. These "Health Resource Partner Institutions" (HRPI) will vary by country, but would include universities, professional associations, national academies of medicine and science, freestanding think tanks, research and development organizations, national management institutes, business, the media, and certain NGOs, all of which can work with ministries and political leaders to create a culture that produces and uses evidence-based policy and programs for health.

While such institutions are common and strong in certain countries (and used effectively by ministries of health), they are missing or rare in others, or those that do exist may not be strong in areas of expertise relating to stewardship and governance by ministries of health. In addition, governments and ministries of health are sometimes insular and reluctant to collaborate with HRPIs. Other government agencies, as well as regional and international organizations, can and do play supportive roles to ministries of health, and these partnerships should be nurtured.

RECOMMENDATION 3

Country Networks of Expertise

Countries should develop effective governmental and non-governmental "Health Resource Partner Institutions" (HRPI) to support the health system stewardship and governance functions of the ministry of health.

Organizations outside government can, and in low- and middle-income countries must, provide needed expertise to ministries of health. In many countries, these organizations themselves will need to be strengthened to provide the level of intellectual and human resources necessary for effective health system performance and governance. A protocol or framework should be developed to guide the **mapping** of other governmental agencies and non-governmental organizations with the capacity or potential to serve as HRPIs for ministries of health at country level. Such a protocol or framework should include agreed upon definitions of the categories of institutions, and a process for gathering information on the resources and relationships HRPIs have, or could provide to ministries. Once these are known and needs are identified, action plans can be developed to strengthen the various partners and enhance their links to the ministries and each other.

Regional actions

As discussed above, there is a critical need for a network of diverse in-country stakeholders and institutions, both within and outside government, to provide expertise and support to the ministries of health. This study also identified a role for *regional* mechanisms to champion the stewardship function of health systems strengthening, and to support the development and networking of HRPIs with ministries of health at country and regional levels.

African Union Health Ministers in two consecutive conferences[6] have called for campaigns to strengthen the implementation capacity of ministries of health, a sentiment that was also echoed in the last World Health Assembly resolution on Primary Health Care.

During the discussions and consultations over the course of this study and in the recent African consultation on the final report, there was wide ranging support for the concept and mission of a pan-African regional mechanism, with ACHEST leading the development effort and serving as the secretariat for the network. The establishment of an "African Health Systems Governance Network" (ASHGovNET) can serve as a potential prototype for such efforts in other regions of the world as appropriate.

ACHEST has already taken the first steps toward operationalizing the ASHGovNET by convening a regional consultation at the end of 2009 in Uganda with broad participation from African organizations and global organizations that provide leadership development and health systems strengthening services to countries in the region. Included were: representatives of

6. Addis Ababa Declaration on the 4th Session of the AU Conference of Ministers of Health (CAMH4); Africa Health Strategy 2007 – 2015. Website addresses for reports of these conferences are provided in Appendix 1.

the AU and regional economic bodies; other African regional networks (e.g. Equinet, AMREF, Health Economics Network); health advocacy organizations; parliamentarians; leaders from academic medicine, public health and business; national management institutes; regional professional associations; regional and international academies of science and medicine; and free standing policy think tanks. To widen interest in and support for the ASHGovNet, ACHEST plans to disseminate the findings and recommendations of this study through presentations to the East, Central, and Southern African (ECSA) Health Community, the Southern African Development Community (SADC), The Economic Community Of West African States (ECOWAS), and other regional forums. Going forward, ACHEST will work with partners to initially select up to 5 countries to map their HRPIs and assess the capacity of ministries to provide health systems stewardship and governance. ACHEST will also work with regional bodies during 2010 to develop a program of work for strengthening stewardship and governance of health systems in Africa, and a strategy for mobilizing resources from within and outside Africa to achieve the set objectives.

Ultimately, a global consortium of such regional networks in the South and North would permit countries to be linked and to learn from each other. Lead nodes for such networks, such as ACHEST, would spearhead development of regional plans of action per the African prototype, adapted accordingly to each region's situation. Through links with the proposed Virtual Global Resource Center (see recommendation 5), these networks could serve as global resources with regional specificity for: informing donor investments in health systems governance in countries of the region; and providing expert advice for the executive leadership development programs (see recommendation 6). Different regional networks could be linked through existing global IT infrastructures sponsored by the World Bank Institute and UNDESA.

RECOMMENDATION 4

Regional Networks for Health Systems Governance

Create a mechanism to mobilize regional resources and provide support and advocacy for effective stewardship and governance of health systems at country level.

In order to accelerate movement at the country level, the establishment of regional networks to champion stronger health systems governance is recommended. It is proposed that this work begin in Africa through the establishment of an African Health Systems Governance Network (ASHGovNET) as a potential prototype for such efforts in other regions of the world as appropriate. This effort would be led in Africa by ACHEST, which would also serve as the secretariat for the network.

ASHGovNET would coordinate a network of the strongest African institutions in the region that agree to: serve as resources to support the work of ministries of health at country level; and advocate for effective governance and stewardship of health systems as critical elements in health systems strengthening at the regional and country level. These institutions could work with WHO to assess ministerial capacity for EPHF and support the "mapping" of Health Resource Partner Institutions (HRPI).

ASHGovNET can work with countries in the region as requested, and can also serve as a convenient access point to international agencies, global initiatives, and donors, offering integrated sources of regional expertise in analysis, programming, and financing for strengthened health system stewardship and governance.

Global Actions

While country and regional level activities are at the core of country health systems strengthening efforts, the influence of global agendas, especially on the governments and ministries of health of LICs, is significant and must be considered. Ministers and global leaders described, for example, the challenges of dealing with multiple health agendas at country level, and managing donor relationships where there may be significant power differentials, or funding stipulations that direct work away from the country's established health priorities. There is also the additional challenge of assuring that the voices of LIC country health leaders are heard and country issues taken into account when global health initiatives are being developed

A supportive policy environment at the global level, and the channeling of global resources, both human and financial, to LIC health ministries, will be critical to achieving and sustaining a focus on the strengthening of health systems stewardship and governance at country level.

Virtual Global Resource Center for Health Systems Stewardship and Governance (VGRC)

Interviewees identified the need for a "one-stop source" for access to high-level global knowledge, technical resources, and leadership development training opportunities that are focused on the governance and stewardship needs of health ministers and ministries. A "Virtual Global Resource Center for Health Systems Stewardship and Governance" (VGRC) is proposed to address this need. The VGRC could be supported by currently available global IT and training platforms and would serve as:

1. a global resource for information sharing and connectivity to create a learning community among ministers and ministries of health; and

2. a vehicle for the development and administration of leadership training offerings for ministers, senior officials in ministries of health, and health related parliamentarians.

A Knowledge Network for Ministers and Ministries of Health

The VGRC would create a community of learning and practice among ministers and ministries of health and those interacting directly with them. The center would provide a "navigator/connector/mobilizer" service that would allow ministers and ministries of health to tap into a menu of information resources; connect with each other to share successes and failures; and make contact with regional and global providers of technical expertise. These resources can help them: address the gaps identified in ministry of health self assessments of their capacity to provide the core governmental functions; meet their staff leadership development and training needs; and support the strengthening of country-based HPRIs.

Health leaders in LICs also face challenges in staying abreast of global developments, especially the successes and failures of country-level health systems reforms and the implementation of health initiatives in other countries. Ministers would greatly benefit from direct and easy to access high-level knowledge resources, and the ability to share experiences and expertise. Ministers also repeatedly expressed concerns about the inherent limitations of the regional technical assistance programs that are available in low-resource regions, including the lack of significant new investment in these programs and lack of access to global resources.

The technological platform for the knowledge network activities of the proposed VGRC would not need to be created anew, but rather the programs could be developed to work in association with the Global Distance Learning Centers that already exist through the infrastructure of the World Bank Institute (WBI) Global Development Learning Network in over 130 countries. This same platform could be linked to the training resources of the WBI, drawing on other global, regional, and national sources of expertise for the leadership development component of the proposed VGRC. Governance arrangements for the work of the proposed VGRC would need to be developed with any sponsoring international agencies and potential "subscribers" to the Center. An expert advisory mechanism should be established to assure that the services are shaped and informed by ministers of health, their HRPIs, and the leaders of the regional networks recommended above. Over time, the VGRC can link to relevant donors and global organizations, and provide a mechanism for systematic collection and distribution of experience, good practice, and sources of consulting and academic expertise in areas specific to effective stewardship and governance of health systems.

RECOMMENDATION 5

A Knowledge Network for Ministers of Health

Create a real-time information resource for ministries of health on best practices in stewardship and governance, and a knowledge network and community of practice among ministries for peer learning.

The World Bank (WB), the World Bank Institute (WBI), and the UN Secretary General have identified global health, and within it, health systems strengthening, as priorities. Each organization manages specific resources that could support the creation of a Virtual Global Resource Center for Health Systems Stewardship and Governance (VGRC). The VGRC could be developed to work in association with the technological platform of the Global Distance Learning Centers that already exist through the infrastructure of the WBI Global Development Learning Network and televideo infrastructure in 130 countries. The VGRC could also link to the global training programs and resources of the WBI and the public administration capacity building resources available through UNDESA and UNDP. In association with relevant country and regional resources, these existing platforms and resources could help support a much needed global "knowledge network" on stewardship and governance for ministries.

A Leadership Development Resource for Ministers and Ministries of Health.

The other component of the VGRC would serve as a vehicle for leadership development programs for new ministers at the global level and ongoing support programs for sitting ministers at regional level. This work is consistent with: the new strategy of the WBI to revise and decentralize its Flagship Course to cover broader topics areas and create more sites and training programs in health systems leadership and management development; and with the recommended linkages of UN agency training resources in public administration and e-government to country health ministries.

Programs should emphasize adult learning principles, focusing on the actual work the ministers do and maximizing action-learning and peer engagement.

Ministers and stakeholders interviewed overwhelmingly supported the capacity-building objectives of the proposed leadership programs, noting that they would be relevant for new and experienced ministers alike. Implementation was considered to be feasible, as long as there are proactive efforts to encourage and accommodate new ministers.

A successful program, according to interviewees, would be developed consistent with adult learning principles and focused on the actual work the ministers while maximizing action-learning and peer engagement. Several interviewees indicated specific information or knowledge that would have been most helpful to them when first starting (n=10), and in their ongoing work (n=13) as minister, including:

- a minister-specific scope of work or description of responsibilities and/or a written handover of what to expect;
- more basic knowledge of health and health issues;
- more health policy knowledge including current health policy, policy making processes, and leadership skills; and
- information on internal and external health related issues.

Suggested program features to optimize minister interest and attendance
• Program relatively brief in duration
• Scheduling consistent with ministers' availability –multiple short sessions /flexible options
• Defraying participants' costs –e.g. scholarships, as local funding for travel expenses may not be available
• Thoughtful promotion of the program and a curriculum with clear utility –practical information and skills needed to run a ministry, including communication, management, advocacy, and partnerships
• New minister programs – held in Geneva or Washington, DC, "where the action is"
• Sitting minister programs – regionally based.

The ability of ministers to provide consistent messages and support to collaborators and ministry staff can help facilitate buy-in to ministerial initiatives and optimize implementation. As such, respondents heavily supported making opportunities for ***mentoring*** and consultation available to new ministers when they return home, with the program facilitating connections between new and experienced or former ministers.

Interviewees felt that training should emphasize ***peer learning,*** providing opportunities for ministers to share lessons learned, impart content and skills to one another, and inspire confidence.

Continued ***access to information*** and ***support*** following the initial training was recommended as a means of reinforcing and supplementing training content and as an opportunity to build a network of health ministers to support one another and to advocate for health interests at a global level.

Other institutions, including WHO and the Gates Foundation, have recognized the need for strengthening the capabilities of ministers and their teams, and interview participants noted that as these programs get underway, ***coordinated efforts*** would be optimal.

Currently available programs and ministers' and stakeholders' specific recommendations for program content are summarized in Appendix 3.

They need to have ongoing resources that can be drawn on easily once they're no longer in session—whether it's tools or individuals or former ministers that can react and support them in dealing with concrete challenges. —Academic Stakeholder

RECOMMENDATION 6

Executive Leadership Development

Create sustainable leadership development training and support for ministers in their own right, and as leaders of ministries of health, to enhance their effectiveness in stewardship of health resources and establishing governance relationships across government and with local and regional institutions from non-governmental sectors.

While the needs of ministries of health as stewards of their health systems are broad, there was strong support for the creation of explicit leadership development opportunities for ministers of health and other senior leaders of ministries. The proposed Virtual Global Resource Center for Health Systems Stewardship and Governance would also support leadership development programs for new ministers at global level; ongoing programs for sitting ministers at regional level; and programs at regional and country levels to strengthen ministerial teams.

A Global Campaign to Raise Awareness of the Importance of Stewardship and Governance in Health Systems Strengthening and the Critical Role of Ministers and Ministries of Health

A global advocacy campaign is needed to continue to raise awareness and understanding among global health leaders, politicians, and the public of:

- the specific role and needs of ministries of health in stewardship and governance of health systems at country level; and
- the global, regional, and country-level activities that are needed to better support ministries in their fulfilling their core mission.

7 RECOMMENDATION

Advocacy for Strengthening Health Ministries

Create and sustain a campaign to raise awareness at country, regional, and global levels of the importance of ministries of health as stewards and participants in strong governance of health systems, and to build financial and policy support for this goal into all initiatives for health systems strengthening.

Immediate action in the form of follow-up conversations and consultations with global officials, donors, and country leaders, and other activities stemming from this report will define a sustained program of advocacy to mobilize political and resource support for ministries of health as stewards of health systems. ACHEST would lead this work in association with key global and regional partners.

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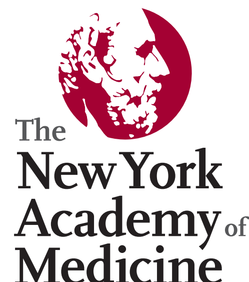

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Appendix 1:

Websites for Selected Resources Cited

Addis Ababa Declaration on the 4th Session of the AU Conference of Ministers of Health (CAMH4) http://afhea.org/Docs/Final_20DECLARATION_2012_205_2009.pdf
Africa Health Strategy 2007 – 2015 http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13 avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf
10 Essential Public Health Services. US CDC National Public Health Performance Standards Program http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm
Essential Public Health Functions. The Pan-American Health Organization/World Health Organization (PAHO/WHO) http://www.paho.org/english/dpm/shd/hp/EPHF.htm
Health Financing Revisited. The World Bank (2006) http://go.worldbank.org/G7FVY2WOK0
Opportunities for Global Initiatives in the Health System Action Agenda. WHO Working Paper No. 4 (2006) http://www.who.int/management/working_paper_4_en_opt.pdf
Public Stewardship of Private Providers in Mixed Health Systems. Commissioned by the Rockefeller Foundation (2009) http://www.resultsfordevelopment.org/products/public-stewardship-private-providers-mixed-health-systems-synthesis-report-rockefeller-foun
Towards Better Leadership and Management in Health. WHO Working Paper No. 10 (2007) http://www.who.int/management/working_paper_10_en_opt.pdf
United Nations Millennium Development Goals http://www.un.org/millenniumgoals/
WHO Commission on Social Determinants of Health - final report http://www.who.int/social_determinants/thecommission/finalreport/en/index.html
Strengthening Health Systems to Improve Health Outcomes. WHO Framework for Action http://www.who.int/healthsystems/strategy/everybodys_business.pdf
World Development Report 2004: Making Services Work for Poor People. The World Bank (2004) http://go.worldbank.org/LOTTGBE9I0
World Health Report 2000 - Health Systems: Improving Performance. The World Health Organization (WHO, 2000) http://www.who.int/whr/2000/en/whr00_en.pdf
The World Health Report 2008 - Primary Health Care (Now More Than Ever) http://www.who.int/whr/2008/en/index.html

Appendix 2:

Core Governmental Functions of Ministries of Health

1. Policy Making
• Initiating, shaping, supporting passage of, and implementing legislation
• Setting national health goals (within the framework of national development plans and programs)
• Coordinating development of a national health/health systems plan, including health workforce needs
• Establishing the framework (priorities and methods) for health systems financing (national, regional and local government funds, ODA, private sector)
• Assuring a mechanism for collaboration/consultation/joint planning across government, across sectors, and with the public to promote health in all policies.
2. Financing and Resource Mobilization
• Advocate for resources for health systems
• National Budget, ODA, private pay revenue allocation and management:
– basic benefits package personal health care; population/public health services;
• research support; workforce employment and training
• Indirect (grants) to regional and local government and grants/contracts to private sector
• Facilitate priority setting for regional and local government raised revenue for allocation/return to center
3. Standard Setting/Regulation (Monitoring and Oversight): Public and Private Sectors
• Provider certification for market participation
• Quality of care standards and oversight
• Standard setting, quality control, regulation (directly or through parastatal)
- drugs, biologics and devices, foods
• Scientific basis for standard setting with other agencies of government, e.g., occupational health and safety, environmental health, etc.
• Licensure of health professionals with Ministry of Education
• Licensure/certification of traditional medicine providers
4. Collecting and Disseminating Information
• Reporting requirements for national funds – all sources
• Public health and vital statistics
• Disease surveillance
• Health care delivery system information
• Workforce data
• Population health surveys
• Research findings
5. Support for Research and Training
• Direct management (see below) or indirect, through financing
6. Technical Assistance/Capacity Building
• Within the ministry
• In regional and local government entities
• In regional organizations
7. Direct (or Contract) Management
• National, regional, local health service providers
• Insurance mechanisms
• Research systems
• Direct training or continuing professional education programs
8. International Liaison
• International relations with other health ministries
• Liaison with international health organizations
• Liaison with health related international technical assistance experts

Appendix 3:

Suggested Leadership Program Content

A global environmental scan conducted as part of this study indicates that there is a lack of leadership development or support programs specifically designed for new or sitting ministers of health. Two currently active leadership programs (the Ministerial Leadership Initiative of R4D and Realizing Rights and a program by Synergos) work with ministerial teams on specific issues such as financing reforms, harmonization and alignment of donor funds, and maternal and child health. Other programs were identified that sponsor occasional briefings for ministers on critical topics. Only one program specifically designed to enhance the leadership capacity of ministers of health was identified (the Harvard International Health Leadership Forum held in 1994-5). While participant satisfaction with the program was high, there was no follow-up when funding ended.

A primary goal of this project was to test the feasibility of a series of programs designed to address this gap in development resources for ministers of health. As part of the interviews, ministers and stakeholders were asked to comment on three specific proposals: an executive leadership development program for new ministers, leadership support for sitting ministers, and the establishment of a virtual information resource center on health systems stewardship and governance.

Participants were supportive of the capacity-building objectives of the proposed programs and made a number of direct recommendations regarding program content. Recommendations clustered into three main content areas: public health policy and practice; collaborating for the public's health; and leadership skills. Specific needs identified in each of these content areas included those that are essentially knowledge-based (e.g. financing mechanisms for health care delivery) as well as those that are more skill-based and could be applied in multiple contexts (e.g. communication, advocacy). Results are summarized in the following table (see **Appendix E** of the full report for further details)

Content Category	Development Emphasis
Public Health Policy and Practice Ministers must be knowledgeable regarding health and health policy	• Leadership development including the basic information needed for: – health needs assessment planning – program development – oversight – reporting • A strong background in the substance of the MOH – key to negotiating with partners from a position of strength • Information and leadership development to support a systems-level approach – necessary given the tendency to see health in terms of specific illnesses or medical services, and the difficulties inherent in addressing health systems
Collaborating for the Public's Health Enhancing ministerial capacity for mutually beneficial collaboration	• Ameliorate the power differential between ministers and partners, allowing ministers to more effectively advocate for health interests and the funding to support those interests. • Background information on the institutions with which they work: – how to "speak the language" of MOH partners (particularly finance) – information necessary to develop persuasive arguments (e.g. economic analysis of health programming), including arguments that support requests for financial or other resources
Leadership Skills The skills needed to utilize basic knowledge in real life settings	• Numerous and varied skills including those related to management, administration, analysis of information, and communication. • Communication (need most often cited by interviewees): – the need to communicate effectively around funding requests – the ability to frame a message that is consistent with the priorities of partners (i.e. health as fundamental to economic development rather than a sector that merely consumes resources) – effective communication with the public and with staff, and the ability to listen and incorporate conflicting views. – the need to access and comprehend the health data that provides the substance of communications, and are necessary to identify service needs and capacities, develop appropriate plans, and report to stakeholders

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